Diabetes Screening Tests, Supplies, Self-Management Training, and Other Services

Overview

Diabetes is the sixth leading cause of death in the United States. Seventeen million Americans have diabetes, and over 200,000 individuals die each year of related complications.[3] These complications include heart disease, stroke, blindness, kidney failure, leg and foot amputations, pregnancy complications, and death related to pneumonia and flu. Diabetes is the leading cause of blindness among adults, and the leading cause of end stage renal disease. With early detection and treatment the development of severe vision loss can be reduced by 50 - 60 percent and kidney failure can be reduced by 30 - 70 percent.

Millions of people have diabetes and do not know it. However, with early detection and treatment the more likely it is that the serious health consequences of diabetes can be prevented or delayed. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, expanded diabetic services covered by Medicare to include diabetes screening for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes. This benefit will help to improve the quality of life for Medicare beneficiaries by preventing more severe conditions that can occur without proper treatment from undiagnosed or untreated diabetes.

Diabetes Mellitus

Diabetes (diabetes mellitus) is defined as a condition of abnormal glucose metabolism using the following criteria.

- A fasting blood glucose greater than or equal to 126 mg/dL on two different occasions.
- A 2-hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions.
- A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Risk Factors

To be eligible for the diabetes screening tests beneficiaries must have any of the following risk factors or at least two of the following characteristics:

Individuals are considered at risk for diabetes if they have any of the following risk factors:

- Hypertension
- Dyslipidemia
- Obesity (a body mass index greater than or equal to 30kg/m2)
- Previous identification of an elevated impaired fasting glucose or glucose intolerance

OR

Individuals who have a risk factor consisting of at least 2 of the following characteristics:

- Overweight (a body mass index greater than 25 but less than 30kg/m2)
- Family history of diabetes

[3] The Centers for Medicare & Medicaid Services. 2004. *Diabetes Brochure* [online]. Baltimore, MD: The Centers for Medicare & Medicaid Services, The U.S. Department of Health and Human Services, 2004 [cited 1 October 2004]. Available from the World Wide Web: (*www.cms.hhs.gov/medlearn/diabetes_brochure.pdf*).

- Age of 65 or older
- A history of gestational diabetes mellitus, or delivery of a baby weighing greater than 9 pounds

New Benefit - Diabetes Screening Tests

Effective with services provided on or after January 1, 2005, Medicare provides coverage of diabetes screening tests for individuals in the risk groups previously listed or those diagnosed with pre-diabetes. This new benefit will allow for earlier diagnosis for Medicare beneficiaries, which will assist in treatment and management of the disease.

Pre-diabetes is a condition of abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100-125 mg/dL or a 2-hour post-glucose challenge of 140-199 mg/dL. The term "pre-diabetes" includes impaired fasting glucose and impaired glucose tolerance.

The diabetes screening blood tests covered by Medicare include:

- A fasting blood glucose test

AND

- A post-glucose challenge test; not limited to
  - an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults

  OR
  - a 2-hour post-glucose challenge test alone

Coverage Information

Effective with services performed on or after January 1, 2005, Medicare provides coverage for diabetes screening tests with the following frequency:

Beneficiaries diagnosed with pre-diabetes

Medicare provides coverage for a maximum of two diabetes screening tests within a 12-month period (but not less than 6 months apart) for beneficiaries diagnosed with pre-diabetes.

Non-diabetic and not previously diagnosed as pre-diabetic

Medicare provides coverage for one diabetes screening test within a 12-month period (i.e., at least 11 months have passed following the month in which the last Medicare-covered diabetes screening test was performed) for non-diabetic and not previously diagnosed with "pre-diabetes".

Who Are Qualified Physicians and Non-Physician Practitioners?

Physician

A physician is defined as a doctor of medicine or osteopathy.

Qualified Non-Physician Practitioner

For the purpose of the diabetes screening blood tests, a qualified non-physician practitioner is a physician assistant, nurse practitioner, or clinical nurse.

Coverage for diabetes screening is provided as a Medicare Part B benefit after a referral from a physician or qualified non-physician practitioner for an individual at risk for diabetes. The beneficiary will pay nothing for this screening (there is no coinsurance or copayment and no deductible for this benefit).

Coding and Diagnosis Information

Procedure Codes and Descriptors

The Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes used to report diabetes screening tests are:

HCPCS/CPT Codes	Code Descriptors
82947	Glucose; quantitative, blood (except reagent strip)
82950	Glucose, post glucose dose (includes glucose)
82951	Glucose; tolerance test (GTT), three specimens (includes glucose)

Table 1 - HCPCS Codes for Diabetes Screening Tests

NOTE: Procedure codes are paid under the Clinical Laboratory Fee Schedule.

Diagnosis Requirements

The screening ("V") diagnosis code V77.1 (Special Screening for Diabetes Mellitus) must be reported. Effective April 1, 2005, a claim that is submitted for diabetes screening where the beneficiary meets the definition of pre-diabetes should report the appropriate HCPCS code(s) with modifier TS. The appropriate diagnosis code is also required on the claim. See CR 3677.

Billing Requirements

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, the appropriate HCPCS code (Table 1) and the corresponding International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code(s) for the service(s) provided must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

See the National Correct Coding Initiative edits web page for currently applicable bundled Carrier processed procedures at *www.cms.hhs.gov/physicians/cciedits* on the CMS website.

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

When submitting claims to FIs, the appropriate HCPCS code (Table 1), the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code(s) must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Types of Bills for FIs

The FI will reimburse for the diabetes screening tests when submitted on the following Types of Bills (TOBs):

Facility Type	Type of Bill
Hospital Inpatient Part B	12X
Hospital Outpatient	13X
Hospital Outpatient - Other	14X
Skilled Nursing Facility (SNF) Inpatient (for Medicare Part B Services)	22X
SNF Outpatient	23X
Critical Access Hospital (CAH)	85X

Table 2 - Facility Types and Types of Bills for Diabetes Screening Services

Special Billing Instructions

- Skilled Nursing Facility (SNF) - When furnished to a beneficiary in a SNF Part A covered stay, the SNF must bill the FI using bill type 22X.
- Generally Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) cannot bill for non-RHC/FQHC services. The diabetes screening tests are considered non-RHC/FQHC services. However, if the RHC or FQHC is provider-based, then the lab tests can be billed for by the base provider to the FI, using the base-provider's ID number. The FI will make payment to the base-provider, not the RHC/FQHC. If the facility is freestanding, then the individual practitioner bills the Carrier for the lab tests using the provider ID number.

Reimbursement Information

Reimbursement of diabetes screening tests is made under the Clinical Laboratory Fee Schedule.

Critical Access Hospitals (CAHs) will be reimbursed at 101% of their reasonable cost.

Maryland hospitals will be reimbursed according to the Maryland State Cost Containment Plan.

Claims from physicians, qualified non-physician practitioners, or suppliers where assignment is not accepted are subject to Medicare's limiting charge.

Reimbursement of Claims by Carriers

Reimbursement for diabetes screening test services is based on the Clinical Laboratory Fee Schedule.

Additional information about the Clinical Laboratory Fee Schedule can be found at: *www.cms.hhs.gov/providers/pufdownload/clfcrst.asp* on the CMS website.

Reimbursement of Claims by Fiscal Intermediaries (FIs)

Reimbursement for diabetes screening test services is based on the Clinical Laboratory Fee Schedule.

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of diabetes screening tests:

- The beneficiary is not at risk for diabetes.
- The beneficiary has already had two diabetes screenings within the past year and has not been identified as having pre-diabetes.

To obtain Carrier and FI contact information please visit *www.cms.hhs.gov/contacts/incardir.asp* on the CMS website.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at *www.wpc-edi.com/Codes* on the Web. Additional information about claims can be obtained from the Carrier or FI.

Diabetes Supplies

In addition to the new diabetes screening tests, Medicare also provides coverage for the following diabetes supplies.

Supplies Covered

Medicare provides limited coverage, based on established medical necessity requirements, for these diabetes supplies:

- Blood glucose self-testing equipment and supplies
- Therapeutic Shoes
  - One pair of depth-inlay shoes and three pairs of inserts

  OR
  - One pair of custom-molded shoes (including inserts), if the beneficiary cannot wear depth-inlay shoes because of a foot deformity, and two additional pairs of inserts within the calendar year
- Insulin pumps and the insulin used in the pumps

NOTE: In certain cases, Medicare may also pay for separate inserts or shoe modifications.

Blood Glucose Monitors and Associated Accessories

Medicare provides coverage of blood glucose monitors and associated accessories and supplies for insulin-dependent and non-insulin dependent diabetics based on medical necessity.

Coverage Information

Coverage for diabetes-related Durable Medical Equipment (DME) is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies. If the provider or supplier does not accept assignment, the amount the beneficiary pays may be higher. In this case, Medicare will provide payment of the Medicare-approved amount to the beneficiary.

For information regarding Medicare's medical necessity requirements and claim filing information, please contact the local DMERC. Please visit *www.cms.hhs.gov/suppliers/dmepos/default.asp* on the CMS website for the name, address, and telephone number of the local DMERC.

NOTE: Medicare allows additional test strips and lancets if deemed medically necessary. However, Medicare will not pay for any supplies that are not requested or were sent automatically from suppliers. This includes lancets, test strips, and blood glucose monitors.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The Healthcare Common Procedure Coding System (HCPCS) codes used to report blood glucose self-testing equipment and supplies are:

HCPCS Codes	HCPCS Code Descriptors
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4259	Lancets, per box of 100
E0607	Home blood glucose monitor

Table 3 - HCPCS Codes for Blood Glucose Self-Testing Equipment and Supplies

For Medicare coverage of a blood glucose monitor and associated accessories, the provider must provide the beneficiary with a prescription that includes the following information:

- A diagnosis of diabetes
- The number of test strips and lancets required for one month's supply
- The type of meter required (i.e., if a special meter for vision problems is required, the physician should state the medical reason for the required meter)
- A statement that the beneficiary requires insulin or does not require insulin
- How often the beneficiary should test the level of blood sugar

Insulin-Dependent
For beneficiaries who are insulin-dependent, Medicare provides coverage for:

- Up to 100 test strips and lancets every month
- One lancet device every 6 months

Non-Insulin Dependent
For beneficiaries who are non-insulin dependent, Medicare provides coverage for:

- Up to 100 test strips and lancets every 3 months
- One lancet device every 6 months

Therapeutic Shoes

Medicare requires that the physician who is managing a patient's diabetic condition document and certify the beneficiary's need for therapeutic shoes. Coverage for therapeutic shoes under Medicare Part B requires that:

- The shoes are prescribed by a podiatrist or other qualified physician.
- The shoes must be furnished and fitted by a podiatrist or other qualified individual, such as a pedorthist, prosthetist, or orthotist.

Coverage Information

Coverage for depth-inlay shoes, custom-molded shoes, and shoe inserts for beneficiaries with diabetes is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies. If the provider does not accept assignment, the amount the beneficiary pays may be higher, and the beneficiary may be required to pay the full amount at the time of service. In this case, Medicare will provide payment of the Medicare-approved amount to the beneficiary.

The physician must certify that the beneficiary meets the following criteria:

- The beneficiary must have diabetes
- The beneficiary must have at least one of the following conditions:
  - Partial or complete amputation of a foot
  - Foot ulcers
  - Calluses that could lead to foot ulcers
  - Nerve damage from diabetes and signs of calluses
  - Poor circulation
  - A deformed foot

The beneficiary must also be treated under a comprehensive plan of care to receive coverage.

For each individual, coverage of the footwear and inserts is limited to one of the following within one calendar year:

- No more than one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes)
- No more than one pair of custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts

Coding and Diagnosis Information

Procedure Codes and Descriptors

The HCPCS codes used to report therapeutic shoes are:

HCPCS Codes	HCPCS Code Descriptors
K0628	For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of Shore A 35 durometer or 3/16 inch material of Shore A 40 (or higher), prefabricated, each
K0629	For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of Shore A 35 durometer or higher, includes arch filler and other shaping material, custom fabricated, each

Table 4 - HCPCS Codes for Therapeutic Shoes

Insulin Pumps

Insulin pumps that are worn outside the body and the insulin used with the pump may be covered for some beneficiaries who have diabetes and who meet certain conditions (criteria listed in following table). Insulin pumps are available through a prescription. Beneficiaries must meet either of the following criteria to receive coverage for an external infusion pump for insulin and related drugs and supplies:

Criteria A	Criteria B
The patient has completed a comprehensive diabetes education program, and has been on a program of multiple daily injections of insulin (i.e. at least 3 injections per day), with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump, and has documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to the initiation of the insulin pump, and meets one or more of the following criteria while on the multiple daily injection regimen: ▸ Glycosylated hemoglobin level (HbAlc) > 7.0 percent ▸ History of recurring hypoglycemia ▸ Wide fluctuations in blood glucose before mealtime ▸ Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL ▸ History of severe glycemic excursions	The patient with diabetes has been on a pump prior to enrollment in Medicare and has documented frequency of glucose self-testing an average of at least 4 times per day during the month prior to Medicare enrollment.

Diabetes needs to be documented by a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method. Continued coverage of the insulin pump would require that the beneficiary has been seen and evaluated by the treating physician at least every 3 months. The pump must be ordered by, and follow-up care of the beneficiary must be managed by, a physician who manages multiple patients with Continuous Subcutaneous Insulin Infusion (CSII) pumps and who works closely with a team including nurses, diabetes educators, and dieticians who are knowledgeable in the use of CSII.

Coverage Information

The Medicare Part B deductible and coinsurance or copayment applies. When covered, Medicare will pay for the insulin pump, as well as the insulin used with the insulin pump.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The HCPCS codes used to report insulin pumps and supplies are:

HCPCS Codes	HCPCS Code Descriptors
K0455	Infusion pump used for uninterrupted parenteral administration of medication, (e.g., epoprostenol or treprostinol)
K0552	Supplies for external drug infusion pump, syringe type cartridge, sterile, each
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each
J1817	Insulin for administration through DME (i.e., insulin pump) per 50 units
K0602	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each
K0603	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each
K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each

Table 5 - HCPCS Codes for Insulin Pumps and Supplies

Billing Requirements

Billing and Coding Requirements Specific to Durable Medical Equipment Regional Carriers (DMERCs)

Beneficiaries can no longer file their Medicare claim forms. The provider must file the form on behalf of the beneficiary.

For information regarding Medicare's medical necessity requirements and claim filing information, please contact the local DMERC. Please visit *www.cms.hhs.gov/suppliers/dmepos/default.asp* on the CMS website for the name, address, and telephone number of the local DMERC.

Reimbursement Information

Reimbursement of diabetes supplies is made by the four DMERCs based on a national Fee Schedule. Medicare Part B deductible and coinsurance do apply. Medicare allows 80% of the approved Fee Schedule.

Claims from physicians, qualified non-physician practitioners, or suppliers where assignment is not accepted are subject to Medicare's limiting charge.

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of diabetes supplies:

- The beneficiary does not have a prescription for the supplies.
- The beneficiary exceeds the allowed quantity of the supplies.

To obtain Carrier and FI contact information please visit *www.cms.hhs.gov/contacts/incardir.asp* on the CMS website.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at *www.wpc-edi.com/Codes* on the Web. Additional information about claims can be obtained from the Carrier or FI.

Diabetes Self-Management Training (DSMT) Services

Medicare provides coverage for DSMT services for beneficiaries who have been recently diagnosed with diabetes, determined to be at risk for complications from diabetes, or were previously diagnosed with diabetes before meeting Medicare eligibility requirements and have since become eligible for coverage under the Medicare Program. DSMT services are intended to educate beneficiaries in the successful self-management of diabetes. A qualified DSMT program includes:

- Instructions in self-monitoring of blood glucose
- Education about diet and exercise
- An insulin treatment plan developed specifically for insulin dependent patients
- Motivation for patients to use the skills for self-management

DSMT services are aimed toward individuals with Medicare who have recently been impacted in any of the following situations by diabetes:

- Problems controlling blood sugar
- Beginning diabetes medication, or switching from oral diabetes medication to insulin
- Diagnosed with eye disease related to diabetes
- Lack of feeling in feet or other foot problems such as ulcers or deformities, or an amputation has been performed
- Treated in an emergency room or have stayed overnight in a hospital because of diabetes
- Diagnosed with kidney disease related to diabetes

The DSMT program should educate beneficiaries in the successful self-management of diabetes as well as be capable of meeting the needs of its patients on the following subjects:

- Information about diabetes and treatment options
- Diabetes overview/pathophysiology of diabetes
- Nutrition
- Exercise and activity
- Managing high and low blood sugar
- Diabetes medications, including skills related to the self-administration of injectable drugs

- Self-monitoring and use of the results
- Prevention, detection, and treatment of chronic complications
- Prevention, detection, and treatment of acute complications
- Foot, skin, and dental care
- Behavioral change strategies, goal setting, risk factor reduction, and problem solving
- Preconception care, pregnancy, and gestational diabetes
- Relationships among nutrition, exercise, medication, and blood glucose levels
- Stress and psychological adjustment
- Family involvement and social support
- Benefits, risks, and management options for improving glucose control
- Use of health care systems and community resources

Coverage Information

Medicare provides coverage of DSMT services only if the physician managing the beneficiary's diabetic condition certifies that such services are needed under a comprehensive plan of care. This plan of care must describe the content, number of sessions, frequency, and duration of the training, and must be written by the physician or qualified non-physician practitioner. The plan of care must also include a statement by the physician or qualified non-physician practitioner and the signature of the physician or qualified non-physician practitioner denoting any changes to the plan of care, if applicable.

The plan of care must include the following:

- The number of initial or follow-up hours ordered (the physician can order less than 10 hours but cannot exceed 10 hours of training)
- The topics to be covered in training (initial training hours can be used to pay for the full program curriculum or specific areas such as nutrition or insulin training)
- A determination if the beneficiary should receive individual or group training

The provider of the service must maintain documentation that includes the original order from the physician and any special conditions noted by the physician. The plan of care must be reasonable and necessary and must be incorporated into the beneficiary's medical record. For coverage by Medicare, DSMT services must:

- Be accredited as a DSMT program by the American Diabetes Association (ADA) or Indian Health Service (IHS)
- Provide services to eligible Medicare beneficiaries that are diagnosed with diabetes
- Submit an accreditation certificate from the ADA, IHS, or another Centers for Medicare & Medicaid Services (CMS)-recognized program to the local Medicare Contractor's provider enrollment department

Medicare will pay for initial training that meets the following conditions:

- Is furnished to a beneficiary who has not previously received initial or follow-up training billed under HCPCS codes G0108 or G0109

- Is furnished within a continuous 12-month period
- Does not exceed a total of 10 hours for the initial training
- The 10 hours of training can be done in any combination of increments of no less than 30 minutes spread over the 12-month period (or a portion of that period)
- With the exception of 1 hour of individual training, training is usually furnished in a group setting with other patients who need not all be Medicare beneficiaries
- The hour of individual training may be used for any part of the training including insulin training

Medicare pays for training on an individual basis for a Medicare beneficiary under any of the following conditions:

- No group session is available within 2 months of the date the training is ordered
- The beneficiary's physician or qualified non-physician practitioner documents in the beneficiary's medical record that the beneficiary has special needs resulting from conditions, such as severe vision, hearing, or language limitations, or other such special conditions as identified by the treating physician or qualified non-physician practitioner, that will hinder effective participation in a group training session
- The physician orders additional insulin training

The need for individual training must be identified by the physician or qualified non-physician practitioner in the referral.

NOTE: If individual training has been provided to a Medicare beneficiary and subsequently the Carrier or FI determines that training should have been provided in a group setting, instead of denying the service as billed, the appropriate actions are down-coding the reimbursement from individual-level to group-level and provider education.

After receiving the initial training, Medicare pays for follow-up training that meets the following conditions:

- Consists of no more than 2 hours individual or group training for a beneficiary each year
- Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries
- Is furnished any time in a calendar year following a year in which the beneficiary completes the initial training (e.g., beneficiary completes initial training in November 2004; therefore the beneficiary is entitled to 2 hours of follow-up training beginning in January 2005)
- Is furnished in increments of no less than one-half hour
- The physician or qualified non-physician practitioner treating the beneficiary must document in the beneficiary's medical record that the beneficiary has diabetes

Coverage for DSMT services is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies. Claims from physicians, qualified non-physician practitioners, or suppliers where assignment was not taken are subject to Medicare's limiting charge.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The HCPCS/CPT codes used to report DSMT services are:

HCPCS/CPT Codes	HCPCS/CPT Code Descriptors
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes

Table 6 - HCPCS Codes for DSMT Services

Services for DSMT must be billed with the appropriate HCPCS/CPT code in 30 minute increments. Providers billing FIs must include the revenue code 0942 along with the appropriate HCPCS/CPT code.

Billing Requirements

General

CMS is designating as certified all providers and suppliers that bill Medicare for other individual services such as hospital outpatient departments, renal dialysis facilities, physicians, and DME suppliers. All providers and suppliers who may bill for other Medicare services or items, and who represent a DSMT program that is accredited as meeting quality standards, can bill and receive payment for the entire DSMT program.

Providers and suppliers are eligible to bill for DSMT services if they are associated with an accredited DSMT program. Billing for DSMT services cannot be submitted as “incident to” services. However, a physician advisor for a DSMT program is eligible to bill for the DSMT service for that program.

Also, the following conditions apply:

- A cover letter and Unique Provider Identification Number (UPIN) must be included with the accreditation certificate.
- The provider must have a provider and/or supplier number and the ability to bill Medicare for other services.
- Registered dietitians are eligible to bill on behalf of an entire DSMT program as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service.

CMS will not reimburse services on a fee-for-service basis rendered to any beneficiary who is:

- An inpatient in a hospital or SNF
- In hospice care
- A resident in a nursing home

DME suppliers are reimbursed through local Carriers.

Claims from physicians, qualified non-physician practitioners, or suppliers where assignment is not accepted are subject to Medicare's limiting charge.

Billing and Coding Requirements When Submitting to Carriers

When submitting claims to Carriers, the appropriate HCPCS code (Table 6) and the corresponding diagnosis code must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting to Fiscal Intermediaries (FIs)

When submitting claims to FIs, the appropriate HCPCS code (Table 6), the appropriate revenue code, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Types of Bills for FIs

As required by CMS, there are eight specific bill types that are applicable for DSMT services. The applicable FI claim bill types for DSMT services are:

Facility Type	Type of Bill	Revenue Code
Hospital Inpatient Part B	12X	0942
Hospital Outpatient	13X	
Home Health Agency (HHA)	34X	
Renal Dialysis Facility (RDF)	72X	
Outpatient Rehabilitation Facility (ORF)	74X	
Comprehensive Outpatient Rehabilitation Facility (CORF)	75X	
Hospital Outpatient Surgery [subject to Ambulatory Surgical Center (ASC) Payment Limits]	83X	
Critical Access Hospital (CAH)	85X	

Table 7 - Facility Types, Types of Bills, and Revenue Code for DSMT

NOTE: The provider's certification must be submitted along with the initial claim.

Coding Tips

The following tips are designed to facilitate proper billing when submitting claims for DSMT services:

- For an hour session, a "2" must be placed in the units column, representing two 30 minute increments.
- Billing an Evaluation and Management (E/M) code is not mandatory before billing the DSMT procedure codes. Do not use E/M codes in lieu of G0108 and G0109.
- The nutrition portion of the DSMT program must be billed using G0108 and G0109. Do not use the Medical Nutrition Therapy CPT codes for the nutrition portion of a DSMT program.
- The DSMT and Medical Nutrition Therapy benefits can be provided to the same beneficiary in the same year. However, they are different benefits and require separate referrals from physicians or qualified non-physician practitioners. The medical evidence reviewed by CMS suggests that the Medical Nutrition Therapy benefit for diabetic patients is more effective if it is provided after completion of the initial DSMT benefit.
- Medicare pays for 10 hours of initial DSMT in a continuous 12-month period. Two hours of follow-up DSMT may be covered in subsequent years.

Tip

- Entities that may participate as RHCs or FQHCs may also choose to become accredited providers of DSMT services, if they meet all requirements of an accredited DSMT service provider. The cost of such services can be bundled into their clinic/center payment rates. However, RHCs and FQHCs must meet all coverage requirements.

Reimbursement Information

Reimbursement for outpatient DSMT is based on rates established under the Medicare Physician Fee Schedule (MPFS).

- Payment may only be made to any provider that bills Medicare for other individual Medicare services.
- Payment may be made only for training sessions actually attended by the beneficiary and documented on attendance sheets.
- Other conditions for fee-for-service payment. The beneficiary must meet the following conditions if the provider is billing for initial training:
  - The beneficiary has not previously received initial or follow-up training for which Medicare payment was made under this benefit.
  - The beneficiary is not receiving services as an inpatient in a hospital, SNF, hospice, or nursing home.

See the National Correct Coding Initiative edits web page for currently applicable bundled Carrier processed procedures at *www.cms.hhs.gov/physicians/cciedits* on the CMS website.

Additional information about MPFS can be found at: *www.cms.hhs.gov/physicians/pfs/* on the CMS website.

While separate payment is not made for this service to RHCs or FQHCs, the service is covered but is considered included in the encounter rate. All DSMT programs must be accredited as meeting quality standards by a CMS-approved national accreditation organization.

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of DSMT services:

- The beneficiary has exceeded the 10-hour limit of training.
- The physician did not order the training.
- The individual furnishing the DSMT is not accredited by Medicare.

To obtain Carrier and FI contact information please visit *www.cms.hhs.gov/contacts/incardir.asp* on the CMS website.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at *www.wpc-edi.com/Codes* on the Web. Additional information about claims can be obtained from the Carrier or FI.

Medical Nutrition Therapy (MNT)

Medicare also pays for Medical Nutrition Therapy for beneficiaries diagnosed with diabetes or a renal disease. For the purpose of disease management, covered services include:

- An initial nutrition and lifestyle assessment
- Nutrition counseling
- Information regarding managing lifestyle factors that affect diet
- Follow-up sessions to monitor progress

This covered benefit provides 3 hours of one-on-one counseling services for the first year and 2 hours of coverage for subsequent years. The dietician/nutritionist may choose how many units are provided per day. Based on medical necessity, additional hours may be covered if the treating physician orders additional hours of Medical Nutrition Therapy based on a change in medical condition, diagnosis, or treatment regimen.

Coverage Information

Medicare provides coverage of Medical Nutrition Therapy services based on a required physician referral; non-physician practitioners cannot make referrals for this service. Medical Nutritional Therapy services must be provided by a qualified dietitian, licensed registered dietitian, a licensed nutritionist that meets the registered dietitian requirement, or a “grandfathered” nutritionist that was licensed as of December 12, 2000.

Coverage for diabetes-related Medical Nutrition Therapy is provided as a Medicare Part B benefit. The beneficiary will pay 20% (as the coinsurance or copayment) of the Medicare-approved amount after meeting the yearly Medicare Part B deductible.

A physician must prescribe these services and renew their referral yearly if continuing treatment is needed into another calendar year.

Coding and Diagnosis Information

Procedure Codes and Descriptors

The HCPCS/CPT codes used to report Medical Nutrition Therapy services are:

HCPCS/CPT Codes	HCPCS/CPT Code Descriptors
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes (**NOTE:** This CPT code must only be used for the initial visit.)
97803	Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Group (2 or more individual(s)), each 30 minutes
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes

Table 8 - HCPCS/CPT Codes for Medical Nutrition Therapy Services

HCPCS/CPT Codes	Instructions for Use
97802	This code is to be used once a year, for initial assessment of a new patient. All subsequent individual visits (including reassessments and interventions) are to be coded as 97803. All subsequent Group Visits are to be billed as 97804.
97803	This code is to be billed for all individual reassessments and all interventions after the initial visit (see 97802). This code should also be used when there is a change in the patient's medical condition that affects the nutritional status of the patient.
97804	This code is to be billed for all group visits, initial and subsequent. This code can also be used when there is a change in a patient's condition that affects the nutritional status of the patient and the patient is attending in a group.

Table 9 - Instructions for Use of the Medical Nutrition Therapy Codes

NOTE: The above codes can only be paid if submitted by a registered dietitian or nutrition professional who meets the specified requirements under Medicare. These services cannot

be paid "incident to" physician services. The payments can be reassigned to the employer of a qualifying dietician or nutrition professional.

Diagnosis Requirements

Medical Nutrition Therapy services are available for beneficiaries with diabetes or renal disease when referral is made by a physician. For diagnosis information for diabetes mellitus, refer to Diagnosis Requirements for Diabetes Screening Tests. For the purpose of this benefit, renal disease means chronic renal insufficiency and the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant within the last 6 months. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation [Glomerular Filtration Rate (GFR) 13-15 ml/min/1.73m^2].

Tips

The DSMT and Medical Nutrition Therapy benefits can be provided to the same beneficiary in the same year. However, they are different benefits and require separate referrals from physicians or qualified non-physician practitioners. The medical evidence reviewed by CMS suggests that the Medical Nutrition Therapy benefit for diabetic patients is more effective if it is provided after completion of the initial DSMT benefit.

Entities that may participate as RHCs or FQHCs may also choose to become accredited providers of Medical Nutrition Therapy services. The cost of such services can be bundled into their clinic/center payment rates. However, RHCs and FQHCs must meet all coverage requirements.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers

When submitting claims to Carriers, the appropriate HCPCS code (Table 8) and the corresponding diagnosis code must be reported on Form CMS-1500 (or the HIPAA 837 Professional electronic claim format).

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries (FIs)

When submitting claims to FIs, the appropriate HCPCS code (Table 8), the appropriate revenue code, and the corresponding diagnosis code must be reported on Form CMS-1450 (or the HIPAA 837 Institutional electronic claim format).

Types of Bills for FIs

As required by CMS, there are two specific bill types that are applicable for MNT. The applicable FI claim bill types and associated revenue codes for MNT are:

Facility Type	Type of Bill	Revenue Code
Hospital Outpatient	13X	0942
Critical Access Hospital (CAH)	85X	

Table 10 - Facility Types, Types of Bills, and Revenue Codes for MNT

Reasons for Claim Denial

The following are examples of situations where Medicare may deny coverage of MNT services:

- The beneficiary is not qualified to receive this benefit.
- The individual furnishing the MNT is not accredited by Medicare.

To obtain Carrier and FI contact information please visit *www.cms.hhs.gov/contacts/incardir.asp* on the CMS website.

Providers may find specific payment decision information on the Remittance Advice (RA). The RA will include Health Care Claim Adjustment Reason Codes and RA Remark Codes to provide additional information on payment adjustments. The most current listing of these codes can be found at *www.wpc-edi.com/Codes* on the Web. Additional information about claims can be obtained from the Carrier or FI.

Other Diabetes Services

In addition to DSMT and Medical Nutrition Therapy services, Medicare provides coverage of the following diabetes services:

- Foot Care
- Hemoglobin A1c tests
- Glaucoma Screening
- Influenza and Pneumococcal Polysaccharide Vaccine (PPV)
- Routine costs, including immunosuppressive drugs, cell transplantation, and related items and services for pancreatic islet cell transplant clinical trials

NOTE: Details regarding glaucoma screening, and influenza and PPV vaccination are described in this Guide. For specific information regarding other diabetes services, refer to relevant CMS documentation.

Diabetic Supplies and Services Not Covered by Medicare

The Original Medicare Plan does not pay for all diabetes supplies and equipment for a beneficiary. The following are excluded from coverage under Medicare Advantage:

- Prescription drugs
- Insulin pens
- Insulin (unless used with an insulin pump)
- Syringes
- Alcohol swabs
- Gauze
- Orthopedic shoes (shoes for individuals whose feet are impaired, but intact)
- Eye exams for glasses (refraction)
- Routine or yearly physical exams
- Weight loss programs
- Injection devices (jet injectors)

NOTE: Coverage of insulin and associated diabetes supplies, including syringes, will begin in 2006.

Written Advance Beneficiary Notice (ABN) Requirements

An Advance Beneficiary Notice (ABN) is a written notice that a provider or supplier gives to a Medicare beneficiary. The purpose of the ABN is to inform a beneficiary, before he or she receives specified items or services that otherwise might be paid for by Medicare, that Medicare probably will not pay on that particular occasion. The ABN allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which he or she may have to pay out of pocket or through other insurance.

Frequently, there is confusion regarding whether an ABN can be used to shift liability to a beneficiary for the cost of non-covered items or services. In making this decision, the provider/supplier first must

determine whether the item or service meets the definition of the Medicare-covered benefit. If the item or service does not meet the definitional requirements for the Medicare-covered benefit, then the item or service will never be covered by Medicare. As a result, the beneficiary will always be liable for the cost of the item or service, and an ABN is not needed to shift liability to the beneficiary.

Beneficiary Notices Initiative (BNI)

BNI is an agency objective to improve agency-to-beneficiary communications to further beneficiary education and health promotion, and to facilitate access to and exercise of individual rights and protections. For more information please visit *www.cms.hhs.gov/medicare/bni* on the CMS website.

If the item or service meets the definition of the Medicare-covered benefit, Medicare still may not pay for the item or service if the item or service was "not reasonable and necessary" for the beneficiary on the occasion in question or if the item or service exceeds the frequency limitation for the particular benefit or falls outside the applicable time frame for receipt of the covered benefit. In these instances, an ABN may be used to shift liability for the cost of the item or service to the beneficiary. If an ABN is not issued to the beneficiary, the provider/supplier may be held liable for the cost of the item or service unless the provider/supplier is able to demonstrate that they did not know and could not reasonably have been expected to know that Medicare would not pay for the item or service.

Diabetes Screening Tests, Supplies, Self-Management Training, and Other Services

Resource Materials

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.
www.cms.hhs.gov/physicians

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule.
www.cms.hhs.gov/providers

Medicare Learning Network
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare providers. For additional information visit the Medicare Learning Network's Medlearn web page at *www.cms.hhs.gov/medlearn* on the CMS website.

Preventive Services Educational Resource Web Guide
www.cms.hhs.gov/medlearn/preventiveservices.asp

Beneficiary Notices Initiative Website
www.cms.hhs.gov/medicare/bni

Carrier and FI Contact Information
www.cms.hhs.gov/contacts/incardir.asp

National Correct Coding Initiative Edits Website
www.cms.hhs.gov/physicians/cciedits

American Diabetes Association, Homepage For Health Professionals and Scientists
www.diabetes.org/for-health-professionals-and-scientists/professionals.jsp

Final Rule, CMS-1429-FC, 42 C.F.R. Parts 40, 405, 410, 411, 414, 418, 424, 484, and 486: Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005
www.cms.hhs.gov/regulations/pfs/2005/1429fc/master_background_1429-fc.pdf

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference D of this Guide.

Notes